White Rose Ob/Gyn Associates
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Welcome to the White Rose Ob/Gyn Associates

Welcome to the White Rose Ob/Gyn Associates. Whether you are here as a gynecological or obstetrical patient, we strive to provide you with exceptional care. Our practice has been providing quality care for over 25 years and are proud to be delivering second generations. We are a family centered practice promoting natural childbirth.

Our practice participates with many insurances. If you are uncertain whether we participate with your insurance, please contact the office or call your insurance company directly.

If you have a copay with your insurance, please be aware that it will be collected at the time of your visit prior to seeing the doctor. You will be given a receipt upon checkout. Failure to pay your copay at the time of your visit will result in a $12.00 billing service charge being added to your account. If you are here for a preventive visit, but have medical concerns addressed and/or treated that are not considered “preventive,” your insurance may subject you to an additional copay. This would be determined based on the contract that you have with your insurance company.

If you are in need of emergency care, you must go to Memorial Hospital unless your insurance specifies otherwise.

If you do not have insurance, full payment will be expected at the time of service unless prior arrangements have been made.

Patients with a credit balance can request a refund at any time.

Thank you for choosing White Rose Ob/Gyn Associates. We look forward to providing you with quality healthcare.

If you have any questions, please contact the office at the above number.

PATIENT NAME: ______________________________

SOCIAL SECURITY #: ______________________________

STREET ADDRESS: ______________________________

CITY: ______________ STATE: ______ ZIP CODE: ____________

BIRTH DATE: ____________ AGE: _____ MARITAL STATUS: ______________

PHONE NUMBER: ______________________________

EMPLOYER: ______________________________

OCCUPATION: ______________________________

SPOUSE/SIGNIFICANT OTHER

NAME: ______________________ SS#: ______________________

EMPLOYER: ______________________________

BIRTH DATE: ______________________________

NAME OF PERSON RESPONSIBLE FOR PAYMENT: ______________________

INSURANCE COMPANY

NAME: ______________________________

PHARMACY NAME: ______________________________

PHARMACY PHONE NUMBER: ______________________________

MEDICAID RECIPIENT NUMBER: ______________________________

FAMILY DOCTOR: ______________________________

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER. ALL COPAYS ARE EXPECTED BEFORE BEING SEEN. PLEASE SEE THE RECEPTIONIST TO MAKE PAYMENT.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO WHITE ROSE OB/GYN ASSOCIATES FOR ANY SERVICES FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT/PHYSICIAN. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION, OR ITS INTERMEDIARIES OR CARRIERS, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM/OTHER INSURANCE COMPANY CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 U.S.C. 3801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION)

SIGNATURE: ____

DATE: ____

NEW PATIENT HISTORY

NAME: ____

DATE: ____AGE_______________________

CURRENT PROBLEM OR REASON FOR VISIT: _________________________________

____

____

PAST FEMALE PROBLEMS: ____

____

____

PAST SURGERIES: ____

____

DATE: ____

ANESTHESIA: ____

HOSPITAL: ____

LIST ANY PROBLEMS YOU HAVE HAD WITH SURGERY OR ANESTHESIA:

____

____

____

LIST ANY OTHER HOSPITALIZATIONS AND THE REASON FOR HOSPITALIZATION:

____

____

MEDICATIONS: ____

____

NAME: ____

DATE: ____

LIST ANY ALLERGIES TO MEDICATIONS OF FOODS: __________________________

____

SOCIAL HISTORY

DO YOU SMOKE: _________ HOW MANY YEARS: _________

HOW MANY PACKS: _________________

DID YOU QUIT: ___________ IF YES, WHEN: __________________________________

DO YOU DRINK ALCOHOL: _______________ HOW MUCH: ______________________

MEDICAL HISTORY

LIST ANY MEDICAL PROBLEMS THAT YOU HAVE: _____________________________

____

____

____

CURRENT BIRTH CONTROL METHOD: _______________________________________

AGE PERIOD STARTED: __________ AGE PERIOD STOPPED: __________________

HOW MANY DAYS DO YOUR PERIODS LAST: _________________________________

DESCRIBE YOUR PERIOD, LIGHT, HEAVY OR FLOODING: ______________________

WHAT WAS THE FIRST DAY OF YOUR LAST PERIOD: _________________________

DO YOU TAKE MEDICATION FOR RELIEF OF CRAMPING DURING YOUR PERIOD:

____

DO YOU HAVE ANY FEMALE/PELVIC PAIN: ___________________________________

IF YES, EXPLAIN: ____

____

DO YOU GET REGULAR PAP SMEARS: _____________________________________

WHEN AND WHERE WAS YOUR LAST PAP SMEAR: __________________________

DO YOU HAVE PAIN WITH INTERCOURSE: __________________________________

DO YOU HAVE ANY ABNORMAL DISCHARGE: ________________________________

DO YOU HAVE FREQUENT FEMALE INFECTIONS: ____________________________

HOW HAVE THEY BEEN TREATED: ____

____

WERE YOU EVER TREATED FOR A PELVIC INFECTION: ______________________

WERE YOU EVER TREATED FOR ENDOMETRIOSIS: __________________________

DID YOU HAVE TROUBLE GETTING PREGNANT: _____________________________

HAVE YOU EVER MISSED A LOT OF PERIODS: ______________________________

DO YOU HAVE ABNORMAL HAIR GROWTH: ___________________________________

DID YOU EVER HAVE BREAST PAIN: ______________________________________

DID YOU EVER HAVE BREAST DISCHARGE: _________________________________

DID YOU EVER HAVE BREAST CYST: ______________________________________

DO YOU HAVE A HISTORY (YOURSELF OR FAMILY) OF BREAST OR OVARIAN CANCER: ____

NAME: ____________________________________ DATE: _______________________

HAVE YOU HAD A MAMMOGRAM: ____

IF YES, WHERE AND WHEN: ____

PREGNANCY HISTORY

NUMBER OF TIMES PREGNANT: ____

DATES OF DELIVERIES: ____

NUMBER OF MISCARRIAGES: ____

NUMBER OF PREMATURE BIRTHS: ____________________________________

HOW MANY LIVING CHILDREN DO YOU HAVE: ___________________________

COMPLICATIONS OF CHILDBIRTH (PLEASE CHECK ANY THAT APPLY)

DIABETES ___ HYPERTENSION ___ INFECTIONS ___ BLEEDING ___

MEDICAL PROBLEMS ___ C-SECTION ___ STILLBORN ___ FETAL DISTRESS ___

FORCEPS ___ VACUUM ___

ANY CHILDREN WITH COMPLICATIONS: ________________________________

MY HEALTH IS:

GOOD: ___ FAIR: ___ POOR: ___

IF YOU HAVE CHECKED POOR OR HAVE ANY HEALTH PROBLEMS OR ISSUES YOU WOULD LIKE TO DISCUSS, PLEASE LIST IT HERE:

____

____

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